

344 Maple Ave W, #102, Vienna, Va. 22180

The Sports Medicine Advisory Committee recommends that member schools adopt this form as a best practice.

This form expires 14 months from the date of the practitioner's signature on page 3.

For school year

(To be filled in and signed by the student and parent/guardian)

PART I - ATHLETIC PARTICIPATION

Male Female

Name _____ Student ID# _____

(Last) (First) (Middle Initial)

Home Address

City/Zip Code

Home Address of Parents _____

City/Zip Code _____

Date of Birth _____ Place of Birth _____

VISAA ELIGIBILITY RULES

To be eligible to represent your school in VISAA championship events or any regular-season competition in a sport in which your school has declared its intention to participate in the VISAA championship, you must meet the requirements of Section 7 of the VISAA rules.

- You must be a regular bona fide student in good standing at the school you represent, taking an average of four hours of classroom instruction per day or at least five academic classes per semester/grade reporting period and working toward graduation requirements at the member school you represent.
- You must be enrolled and in attendance at the member school at least 30 days prior to the date of the start of the VISAA championship in that sport.
- You must not have reached the age of 19 on or before August 1 of the school year in which you wish to compete.
- You must be enrolled in grades eight through twelve.
- You must not have completed the graduation requirements of a school for any diploma category during the preceding academic year.
- You must not have been classified as a senior at any school during a preceding academic year.
- You must not have been ruled ineligible by your school's conference.
- You must be in compliance with VISAA amateurism rules.
- You must not receive financial aid based on athletic participation, and only receive aid in accordance with your school's regular financial aid policies.
- If you transferred from one VISAA member school to another, then you are eligible to compete immediately in a varsity sport at your new school provided that you (a) are in good financial standing upon departure from the first school and you receive a statement of release of financial obligations from the first school, (b) have not engaged in competition in that sport during the current season at your first school, and (c) meet all other VISAA eligibility requirements.

Participation in interscholastic athletics is a privilege you earn by meeting not only the above-listed eligibility standards, but also all other standards set by your conference and school. If you have any question regarding your eligibility or are in doubt about the effect an activity might have on your eligibility, **check with your school administration for interpretations of VISAA rules.** Meeting the intent and spirit of VISAA standards will prevent you, your team, school, and community from being penalized. Additionally, I give my consent and approval for my picture and name to be printed in any school or VISAA athletic program, publication or video.

→Student Signature: _____ Date: _____

→Parent/Guardian Signature: _____ Date: _____

PROVIDING FALSE INFORMATION MAY RESULT IN INELIGIBILITY

PART II - ACKNOWLEDGEMENTS OF RISK AND INSURANCE STATEMENT

(To be completed by parent/guardian)

I give permission for _____ (name of child/ward) to participate in any of the following sports that are NOT crossed out: baseball, basketball, cheerleading, cross country, field hockey, football, golf, lacrosse, soccer, softball, swim/dive, tennis, track, volleyball, wrestling, other (identify sports): _____

I have reviewed the individual eligibility rules and I am aware that with participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts or some other means. He/she has student medical/accident insurance available through the school (yes__ no__); has athletic participation insurance coverage through the school (yes__ no__); is insured by our family policy with:

Name of medical insurance company: _____

Policy number: _____ Name of policy holder: _____

I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team.

I hereby consent to allow the physician(s) and other health care provider(s) selected by me or the school to perform a pre-participation examination on my child and to provide treatment for any injury or condition resulting from participation in athletics for his/her school during the school year covered by this form. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation in athletics with coaches and other school personnel as deemed necessary.

Additionally, I give my consent and approval for the above named student's picture and name to be printed in any high school or VISAA athletic program, publication or video.

To access quality, low-cost comprehensive health insurance through FAMIS for your child, please contact Cover Virginia by going to www.coverva.org or calling 855-242-8282.

PART III - EMERGENCY PERMISSION FORM*

(To be completed and signed by the parent/guardian)

STUDENT'S NAME: _____ GRADE: _____ AGE: _____ DOB: _____

HIGH SCHOOL: _____ CITY: _____

Please list and significant health problems that might be significant to a physician evaluating your child **in case of an emergency**:

PLEASE LIST ANY ALLERGIES TO MEDICATIONS, ETC: _____

IS THE STUDENT CURRENTLY PRESCRIBED AN INHALER OR EPI-PEN? _____ LIST THE EMERGENCY MEDICATION: _____

IS THE STUDENT PRESENTLY TAKING ANY OTHER MEDICATION? _____ IF SO, WHAT? _____

DOES THE STUDENT WEAR CONTACT LENSES? _____ DATE OF LAST Tdap OR Td (TETANUS) SHOT: _____

EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of _____ (school) to hospitalize, secure proper treatment for and to order the injection and/or anesthesia and/or surgery for the person named above.

WHERE TO REACH YOU IN AN EMERGENCY: Cell Phone _____ Other Phone _____

→ **SIGNATURE OF PARENT/GUARDIAN:** _____ **DATE:** _____

RELATIONSHIP TO STUDENT: _____

*Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment in needed.

→ **I CERTIFY ALL OF THE ABOVE INFORMATION IS CORRECT:** _____

Parent/Guardian signature

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Student's Name: _____

Date of Birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

☐ Medically eligible for certain sports

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations:

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other Information: _____

Emergency Contacts: _____

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Male: _____ Female: _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots
☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions: _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). _____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response)

	<u>Not at all</u>	<u>Several Days</u>	<u>Over half the days</u>	<u>Nearly every day</u>
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes)

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- Consider additional questions on more-sensitive issues.
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?

- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____ Weight: _____		
BP: _____ / _____ (_____ / _____) Pulse: _____ Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: <input type="checkbox"/> Y <input type="checkbox"/> N		
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes, ears, nose, and throat		
Lymph nodes		
Heart ^a		
Lungs		
Abdomen		
Skin		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional		

^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

KENSTON FOREST SCHOOL

CONCUSSION INFORMATION

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. A concussion can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:	
<ul style="list-style-type: none"> • Headaches • “Pressure in head” • Nausea or vomiting • Neck pain • Balance problems or dizziness • Blurred, double, or fuzzy vision • Sensitivity to light or noise • Feeling sluggish or slowed down • Feeling foggy or groggy • Drowsiness • Change in sleep patterns 	<ul style="list-style-type: none"> • Amnesia • “Don’t feel right” • Fatigue or low energy • Sadness • Nervousness or anxiety • Irritability • More emotional • Confusion • Concentration or memory problems (forgetting game plays) • Repeating the same question/comment

Signs observed by teammates, parents and coaches include:
<ul style="list-style-type: none"> • Appears dazed • Vacant facial expression • Confused about assignment • Forgets plays • Is unsure of game, score, or opponent • Moves clumsily or displays uncoordination • Answers questions slowly • Slurred speech • Shows behavior or personality changes • Can’t recall events prior to hit • Can’t recall events after hit • Seizures or convulsions • Any change in typical behavior or personality • Loses consciousness

What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under-report symptoms of injuries, concussions are no different. As a result, education of administrators, coaches, parents and students is the key to student athletes' safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. The new "Zackery Lystedt Law" in Washington now requires the consistent and uniform implementation of long and well-established return-to-play concussion guidelines that have been recommended for several years:

"A youth athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time..."

and

"...may not return to play until the athlete is evaluated by a licensed health care provider trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider."

You should also inform your child's coach if you think that your child may have a concussion. Remember that it is better to miss one game than miss the whole season. And *"when in doubt, the athlete sits out."*

For current/updated information on concussions you can go to:

<http://www.cdc.gov/ConcussionInYouthSports/>

Return to Play (RTP) Procedures after a Concussion

1. Return to activity and play is a medical decision. The athlete must meet all of the following criteria in order to progress to activity:

Asymptomatic at rest and with exertion (including mental exertion in school) AND have written clearance from their primary care provider or concussion specialist (athlete must be cleared for progression to activity by a physician other than an Emergency Room physician, if diagnosed with a concussion).

2. Once the above criteria are met, the athlete will be progressed back to full activity following the step-wise process detailed below. (This progression must be closely supervised by a Certified Athletic Trainer. If your school does not have an athletic trainer, then the coach must have a very specific plan to follow as directed by the athlete's physician).
3. Progression is individualized, and will be determined on a case-by-case basis. Factors that may affect the rate of progression include: previous history of concussion, duration and type of symptoms, age of the athlete, and sport/activity in which the athlete participates. An athlete with a prior history of concussion, one who has had an extended duration of symptoms, or one who is participating in a collision or contact sport may be progressed more slowly.
4. Stepwise progression as described below:

Step 1: Complete cognitive rest. This may include staying home from school or limiting school hours (and studying) for several days. Activities requiring concentration and attention may worsen symptoms and delay recovery.

Step 2: Return to school full-time.

Step 3: Light exercise. This step cannot begin until the athlete is no longer having concussion symptoms and is cleared by a physician for further activity. At this point the athlete may begin walking or riding an exercise bike. No weight-lifting.

Step 4: Running in the gym or on the field. No helmet or other equipment.

Step 5: Non-contact training drills in full equipment. Weight-training can begin.

Step 6: Full contact practice or training.

Step 7: Play in game. Must be cleared by physician before returning to play.

- The athlete should spend 1 to 2 days at each step before advancing to the next. If post-concussion symptoms occur at any step, the athlete must stop the activity and the treating physician must be contacted. Depending upon the specific type and severity of the symptoms, the athlete may be told to rest for 24 hours and then resume activity at a level one step below where he or she was (level) when the symptoms occurred.

KENSTON FOREST SCHOOL CONCUSSION INFORMATION FORM

Please sign this form acknowledging that you have read the Kenston Forest Concussion Information and return this page to the Athletic Director on the first day of the season. The department must receive the form before an athlete may begin practice.

_____ Student-Athlete Name (Printed)	_____ Student Athlete Signature	_____ Date
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_____ Parent/Guardian Name (Printed)	_____ Parent/Guardian Signature	_____ Date
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